New England Deaconess Hospital

pulse

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Operating room nurses Pam Badger (l) and Nancy Donovan count all instruments before surgery begins.

Operating room nurses provide total care for surgical patients

"His blood pressure has dropped fifteen points . . ." says the anesthesiologist to the surgeon and operating room nurse (ORN). Sharon St. Ledger, head of the cardiology surgical nursing team, moves over to the heart and lung machine to assess the unit's performance. The machine is taking over the patient's heart and lung functions during the coronary by-pass operation.

Moments later the crisis has passed and the surgical team settles down again. The rhythm of surgery was never broken, just accelerated.

During any operation, the focus of attention is on the patient as well as on the surgeons as they perform their intricate work. The less publicized side of surgery is routinely performed by the rest of the surgical team, led by the ORN.

However, a major part of the team will soon be receiving recognition when the hospital initiates the first hospital-based ORN course for nurses in the northeast, starting in February.

Also the national spotlight was on the ORNs earlier this month when the Association of Operating Room Nurses, Inc. (AORN) designated November 14 as "Operating Room Nurse's Day." Various representatives from the association spent the day reminding consumers of their right to professional nursing care in the operating room. They also explained the ORN's perioperative role – a phrase which encompasses the pre-, intra- and postoperative stages of nursing care.

The need to publicize the ORN's role arises from the recent attempt by the Department of Health, Education and Welfare to change the current law requiring that a registered nurse circulator provide the nursing care during surgery (where Medicaid/Medicare reimbursement is involved).

AORN states that the perioperative functions performed by the ORN require professional judgments and skills acquired only in RN education programs. However, many nursing schools don't teach nurses specifically to function in the OR.

"Some time ago, educators decided that ORNs performed technical skills, not nursing," said Margaret A. Burns, director of surgical services at the Deaconess. "That concept is not valid now since OR nursing has become very complex. Because of this hospitals are now facing a nation-wide shortage of ORNs. Hospitals usually have to train ORNs on-the-job for five to six months, which takes a lot of staff time and doesn't meet the demand for knowledgable ORNs. Most hospitals want nurses already experienced in OR nursing."

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New NEDH tests cut stroke risk

For many elderly people, the prospect of suffering a stroke is the most dreaded affliction that could possibly strike in the autumn years of their lives. And no wonder – unlike other diseases whose effects can sometimes be reversed, there presently is little active medical treatment for the person who has sustained a stroke and the damage is overwhelming. Almost 50 percent of stroke victims die within 30 days of an attack. Of the remainder, only one in ten recovers enough to resume a normal life. The rest are left with varying degrees of permanent paralysis, usually robbed of their abilities to concentrate and read. These losses, in turn, often contribute to an emotional crippling as the stroke victim despairingly faces the future.

Prevention now seems to offer the only real hope for decreasing this debilitating condition. Until recently the only diagnostic tests available to

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Smoking program viewed as model

The Deaconess takes 'no smoking' seriously. Employees and visitors have realized this for two years now, but slowly the hospital has been acknowledged by health care and educational institutions throughout New England as a model for setting up smoking policies and programs.

"Cancer News", a national American Cancer Society publication, published an article on the Deaconess program this month, while Dr. Joseph Andrews has recently lectured on the program at a state-wide American Lung Association meeting in New Hampshire, the Sidney Farber Cancer Institute and at a meeting of the Massachusetts Public Health Association.

Last month he spoke before an American Cancer Society conference of hospital administrators from all over Massachusetts. The presentation will be used by the Regional Cancer Control Committee as part of their lecture tour of the state.

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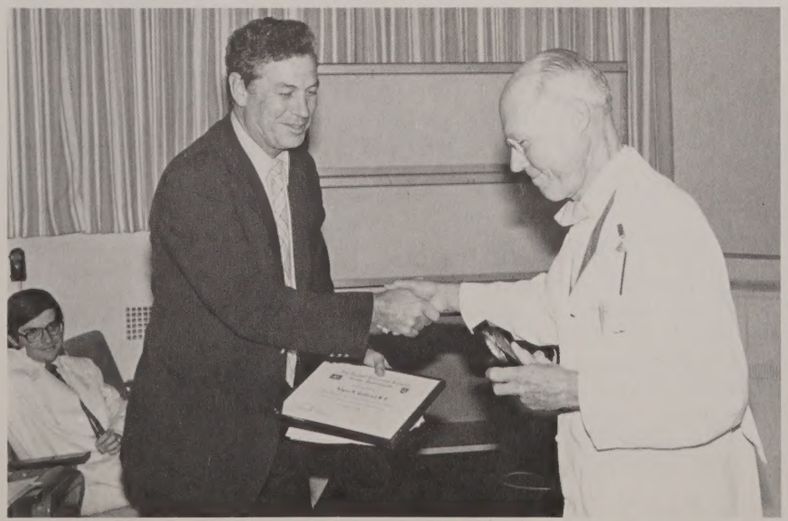

Dr. James L. Tullis (r), chairman of the Department of Medicine, presents the Tullis Lectureship award to Dr. Edgar S. Cathcart, professor of medicine at Boston University.

Deaconess medicine holds alumni meeting

The New England Deaconess Hospital Department of Medicine House Officer Alumni Association held its annual reunion in the Joslin Auditorium on October 17.

Alumni members, senior medical staff and Deaconess house staff received papers from Dr. William E. Anderson, Jr. on the "Simultaneous Measurement of Glucose and Insulin Levels in the Management of Diabetic Therapy," and from Dr. Joseph C. Corkery on "Inhibition of Estrogen Synthesis by Aminoglulethimide."

During the meeting Dr. Edgar S. Cathcart received the James L. Tullis Lectureship Award for a paper on "Pathogenesis of Amyloid Disease." The prize is awarded annually to a medical resident or alumnus for an original paper or project completed during residency training.

Dr. Cathcart was a medical resident at the Deaconess during 1957-58. Since then he has published 83 medical papers, and currently is professor of medicine at Boston University.

The alumni reunion day concluded with a banquet at The Country Club in Brookline.

Building services: the "invisible" workers

Just mention the words "hospital personnel" at the Deaconess and see what images immediately pop into mind – "physicians", "nurses", "technicians" and "technologists", a virtual wave of white uniforms. Somehow it's easier to overlook the hundreds of other employees who quietly blend into the hospital setting. Truly, they belong to a cadre of behind-the-scene workers who make the Deaconess "tick."

One such group is building services, formerly known as the housekeeping department, now headed by Mr. Peter Dalton. Its members work throughout the hospital engaged in the monumental task of keeping the Deaconess in a high state of medical cleanliness. Usually when one of them comes to your attention (the women wear pink dresses while the men are in grey pants and striped shirts) they're busy wielding a floor buffer, sponging a wall, stripping a bed, vacuuming a floor or running a service elevator.

Maria Barczyn, building services, keeps the third floor of the School of Nursing spotless.

During the day shift 41 women and 25 men perform a variety of jobs in the patient care areas. A typical week brings 350 patient discharges, and with them each a room and bath must be spotlessly cleaned and prepared for the next patient. Other daily tasks involve shampooing the carpeted floors in the Farr building, removing a mountain of hospital trash, washing and waxing patient floors and cleaning furniture.

The evening shift which works from 5:30 - 9:30 p.m. under the direction of Mr. Larry Tempesta and Mr. Richard White numbers 48 people. With the hospital beyond "rush hour" pace their attention now centers on cleaning the non-patient areas; the Meissner Laboratories, Cancer Research Institute, Farr Lobby and the Baker, Palmer and Deaconess corridors. Two night shift workers apply the final touches from 11 p.m. to 7 a.m.

In his recent book entitled *Working*, Studs Terkel explored the satisfactions and shortcomings various American workers experience in their jobs. Mr. Dalton said he finds that most of his workers get an immediate sense of satisfaction in seeing their labor restore the hospital to cleanliness and order.

Mr. James Dillahunt has been on the building services day shift for the past 13 years spending his time exclusively on Palmer 3. Mr. Dillahunt takes pride in his work and considers Palmer 3 as "his floor".

"I like keeping things clean for the sick people. I feel a part of the whole team on my floor."

Maria Barczyn has worked five years at the Deaconess spending the last three maintaining the first and third floors at the School of Nursing. She has her hands full on the third floor cleaning up after 44 dormitory nursing students.

"Some women don't like working with the students but I find them to be a nice bunch of kids. I'm always so busy that the time goes by fast. And after I clean and see it that way, I get a real good feeling."

James Dillahunt takes extra pride in his work on Palmer 3.

Stroke
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identify potential stroke victims were X-ray angiograms. These tests use injected dyes to reveal blockages in the blood vessels, a condition that can lead to a major stroke. Unfortunately, angiograms have their drawbacks as a routine screening device. They can cost up to $1000 to administer as the patient must be hospitalized for a day or two and they carry a slight attendant medical risk.

Recently, the Noninvasive Vascular Laboratory of the New England Deaconess Hospital headed by Dr. Alfred V. Persson, director, and Dr. Gary W. Gibbons, assistant director, has assumed a leadership role in reducing the 40 percent of strokes caused by disease of the internal carotid artery. Over the past year the vascular lab has added several new diagnostic tests which can quickly, painlessly and inexpensively show blockages in the carotid arteries leading to the brain.

Early detection of these buildups of plaque blockages composed of hardened calcium, cholesterol, blood platelets and fibrin offers surgical options for their removal before harm strikes. If left unattended, however, advanced accumulations of plaque can shut off the flow of blood feeding oxygen to the brain, resulting in a massive stroke. Or just as easily a piece of plaque can break off and float into the brain causing a partial stroke.

The two new stroke screening tests are given in pairs to patients suspected of having arterial blockages. Patients over 60 years of age who also have one or more accompanying risk factors of diabetes, hypertension or heavy cigarette smoking are prime test candidates.

The first test, oculoplethysmography or OPG, costs $60 and is based on the principle that since the first branch of the internal carotid artery is the ophthalmic artery, the eye acts as a "window" to the health of the internal carotid artery. If disease has narrowed the artery reducing blood flow, the volume of blood reaching the eye during a pulse will be delayed compared to a normal eye.

An OPG technician places small cups similar to contact lenses over the patient's eyes. These cups contain built-in sensors which measure and record blood volume changes in the eyes during pulsations. Measured delays in the volume of blood reaching the eyes during pulsation alerts the technician to a possible carotid blockage.

Patients who show positive indications on the OPG undergo a second test called an echoflow. The echoflow uses a high powered microphone to record noises made by movement of blood through the carotid arteries and displays them on an oscilloscope. Analysis of these sounds can pinpoint the location of a "bruit" (noise) caused by narrowing of the artery and can help estimate the extent of narrowing and disease.

During the past year approximately 1200 patients have undergone testing in the Deaconess Vascular Lab. Together, the two tests give an accuracy level of 90 percent. They provide an effective screening test for determining which patients would benefit from further angiogram testing and possible surgery.

Cluster units formed in oncology and pulmonary

The clustering of oncology and pulmonary/thoracic patients in order to achieve specialized care from the medical and supportive services staffs has been initiated on Farr 8 and 10.

Grouping patients is not a new concept – hospitals generally designate certain floors as being medical or surgical, but clustering enables a staff to focus completely on a specific number of patients who have the same disease.

The oncology cluster unit (OCU), set up for approximately 20 patients on Farr 10, has been in operation since mid-September. "Clustering cancer patients helps us to be more aware of their needs. As medicine becomes more specialized, we're able to offer patients better and more intensive care," said Joanne Perri, clinical nurse specialist of the unit. For example, cancer patients receiving chemotherapy and radiation treatments often don't feel like eating when scheduled. In the OCU, the patient will be able to eat on demand, thus improving his or her nutritional status.

The cluster will not always be exclusively oncology patients since the hospital maintains a high census and beds are in constant demand. All patients with the diagnosis of cancer are eligible for admission to the cluster. Patients previously managed within the unit will be preferentially admitted.

"We want the patient to identify with the health care team," said Ms. Perri, "The patient knows the nursing staff is there because they're committed to the oncology patient." The OCU team, headed by Dr. Jacob Lokich, chief of medical oncology, includes social services, physical therapy, dietary, pastoral care, rehabilitation and psychiatry. Of course, the same services are available to oncology patients throughout the hospital, but clustering allows for a concentrated effort in all areas of treatment and care. Another major benefit of the OCU is the opportunity to optimize the expertise of the staff by providing continuing education seminars for not only the OCU participants, but for staff members throughout the hospital as well.

The nursing staff, supervised by A. Eileen Bozadjian and Mary Lea Savage, will be specifically responsible for the bulk of the OCU functions: direct delivery of chemotherapy, patient and family instruction, initiation of all support services, etc.

The pulmonary/thoracic cluster, with 40 beds on Farr 8, officially opened on October 29, but is not yet in full operation. The unit, overseen by head nurses Mary Beth Green and Shirley Baldwin; unit clerk Anne Cronin; Elizabeth Dunbar, nursing care coordinator; and Suzanne Burge, nurse clinician; will accept all pre- and postoperative pulmonary patients, except for those who require admission to the intensive care unit or recovery room.

Sharon St. Ledger, head of the ORN cardiology team, answers a patient's questions before he enters surgery.

Unified "patient bill of rights" becomes law in Massachusetts

The Massachusetts "Patient's Bill of Rights," which became effective on August 21, is actually a codification of existing law and conduct that is already standard procedure in most hospitals.

The purpose of the bill, according to one of its drafters, State Senator John King, is to make consumers aware of their rights as patients. "We didn't add any new rights," explained Senator King at a recent Massachusetts Hospital Association (MHA) briefing on the statute. "The bill took 15 years to complete since many groups and individuals were involved in drafting the final version. Naturally, it's not the last word." Despite the need for clarification in parts, the bill is straightforward and easily understood.

Essentially the bill outlines the hospital's and physician's responsibilities to the patient. Some of the provisions include:

1. Requiring the hospital to make available to the patient "written notice" of the rights established by the law upon the patient's admittance; and conspicuous posting of these rights.

2. The right of the patient to refuse to be examined, observed or treated by students or any facility staff . . . (this imposes a duty on the hospital to inform the patient if students are to be involved in certain procedures in order to obtain the patient's consent).

3. The patient's right to refuse to serve as a research subject and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic.

4. In the case of a patient suffering from any form of breast cancer, the physician must provide complete information on all alternative treatments which are medically viable.

Information on patient's rights are printed in the Deaconess "As You Enter" booklet, distributed to patients upon their admittance. A revised booklet, containing the entire new version of the law as passed on August 21 will be available from Patient Services in December.

NEDH raises $30,000 for United Way

1979 was indeed a vintage year for the United Way Appeal at NEDH. Thanks to the generosity of Deaconess employees and physicians, contributions reached an all time high of $30,133.40. Total giving increased by almost 23% over 1978 as 1023 donors pledged an average gift of $29.45.

United Way donations help support 162 human care agencies which deliver health counseling, family, child, and youth services to more than 650,000 people in the Massachusetts Bay area.

Martin E. Cernek, chairman of the United Way Appeal at the Deaconess, credits the hard work of Suzanne Holloran, keyperson elect, area captains and solicitors for the drive's success.

"We're extremely pleased and gratified at the response from Deaconess people. It certainly shows a caring for others."

Getting Ready – *Deaconess employees (l-r) Sue Kelly, surgical services; Kevin Welsh, laundry; and Carol Rundle, surgical services, prepare for a four-mile United Way road race along Charles River in Boston. Of 267 runners, Mr. Welsh finished 34th; Ms. Rundle, 113th, and Ms. Kelly, 171st.*

ORN

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NEDH has decided to initiate a 20-week pilot program for RNs who wish to become ORNs. The response was overwhelming since OR nursing is quite popular despite the tension and demanding work, especially at the Deaconess where most of the surgical cases are major and complex. Ms. Burns has applied for a federal grant in order to fund a school of OR nursing based at the Deaconess, in affiliation with the Lahey Clinic and Massachusetts General Hospital. Martha Griffin, a former Deaconess nurse and ORN instructor at the New England Baptist Hospital, will teach the course.

The 30 Deaconess ORNs work either from 7:00 a.m. to 3:30 p.m. or 10:00 a.m. to 6:30 p.m. Every night one nurse and two technicians are on call until 6:30 the next morning. The cardiac team (9 members) is always on call. ORNs are expected to be in the hospital, completely prepared for surgery, thirty minutes after receiving a call.

The routine of setting up an OR varies according to the type of surgery scheduled. Some cases require more monitoring equipment and staff. Before surgery the ORN makes sure the OR is absolutely clean, all equipment is working and supplies and drugs are prepared. Meanwhile the scrub person lays out the sterile instruments and materials needed for the particular operation. During this preparation, the ORN visits the patient waiting area to identify the patient, review his or her charts and assess the patient's emotional and physical status in order to set up a plan of care based on the patient's individual needs.

The ORN returns to the OR to count the instruments and sponges with the scrub person. By this time, the patient arrives and is transferred to the operating table as the anesthesiologist and ORN chat with the patient, explaining what they are doing as they go along.

"We position the patient, being careful to maintain the same body alignment throughout the procedure," said Norma Allen, assistant head ORN, "The patient is checked to be sure no injury has occurred during transfer, then the surgeon talks to the patient before the anesthesia takes effect."

After the patient is under anesthesia, the surgeon applies the prep solution to the surgical site and the patient is draped – completely covered except for the area being operated on. The ORN adjusts the lights and equipment, then surgery begins.

The circulating ORN is always on the move, anticipating the surgeon's needs – keeping one step ahead of the action. The ORN is constantly evaluating data – the effects of fluid loss on the patient, distinguishing between normal and abnormal cardiopulmonary information, checking changes in the patient's pulse, respiration, temperature and blood pressure.

The ORN maintains the controlled, sterile environment while communicating with those outside of the OR – ordering X-rays, reports of special tests, sending out for blood tests and preserving specimens.

Throughout the operation, which can last anywhere from one to twelve

ORN Debbie Nelson prepares drugs during surgery.

hours, the ORN keeps records of the proceedings, monitors aseptic technique and records any unusual situations.

After the final instrument and sponge counts the patient's wound is closed and the ORN accompanies the patient to the recovery room to report on the patient's needs and to describe any complications or specific requirements. After discussing the patient's condition, the ORN returns to the OR to repeat the basic tasks for the next case, usually three to four times a day.

The pressure of meeting the needs of surgeons and patients is unrelentless, but challenging. Once adjusting to the first few years of being an ORN, the nurse seems to thrive on it, enjoying the constant changes in nursing care and surgical techniques.

Diane Gulczynski, one of the head ORNs, emphasized the reason operating room nurses belong in the OR, "Everyone on the surgical team has his or her specific job and gets involved with that, but the ORN is always involved in the patient's safety, privacy and total well-being while he or she is under anesthesia. We serve as the patient's advocate in the operating room."

Deaconess nurses, doctors, employees and patients gather on Farr 8 to say goodbye to Natalie Zerega, a retarded diabetic patient who has spent 1½ years at the hospital. Ms. Zerega, who greatly enjoyed her farewell cake and many gifts, left the hospital on November 10.

Deaconess News in Brief

Articles published

Dr. George Blackburn and **Ruth Clark,** NEDH dietitian, have written an article on weight loss programs which was published in the November 20 issue of "Family Circle" magazine.

Martha L. Eichhorn, assistant director for patient care, was co-author of an article entitled "Evaluation of a Primary Nursing System Using the Quality Patient Care Scale", which appeared in the "Journal of Nursing Administration" last month.

Joyce Tower named president elect

Director of Dietetics **Joyce Tower** has been voted president elect of the Massachusetts Dietectic Association, and has been named to the advisory committee of the Massachusetts Nutrition Resource Center.

Associate director Campisano presents paper

Peter Campisano, associate director, recently presented a paper on the "Political Economy of Health Care Regulation" at the 107th annual meeting of the American Public Health Association in New York.

Blood Bank receives AABB accreditation

The **NEDH Blood Bank and Transfusion Service** has been awarded a two-year accreditation from the American Association of Blood Banks (AABB). Accreditation follows an intensive on-site inspection by AABB representatives who establish that the level of medical, technical and administrative performance within the facility meets or exceeds the AABB standards. It is not necessary for a blood bank or transfusion service to be legally accredited, according to Dr. Agnes Kim, blood bank director, but the NEDH sought accreditation because it represents a level of professional and medical expertise that meets and exceeds government regulations. The primary goal of the AABB is to assist facilities in providing higher quality blood, blood products and services to patients.

Smoking

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"With the steady rise in smoking-related illnesses, medical institutions need to assume a leadership role in prevention by helping smokers to stop smoking. Fewer than 5% of the nation's 7200 hospitals are involved in the anti-smoking effort," said Dr. Andrews, chairman of the hospital smoking committee.

Despite our maintaining a leadership role, progress within the hospital has been slow though steady. "We decided to develop a smoking policy supportable by all hospital personnel in order to produce more lasting results, said Dr. Andrews, "Our secret was to make space for smokers."

The Deaconess smoking policy is still evolving. The smoking committee, made up of nurses, employees, hospital administrators, physicians and representatives from various state agencies and Boston hospitals, continues to meet monthly. Plans are underway to move the Farr lobby smoking area for visitors to a room downstairs in the Baker building. The committee is also working with the American Lung Association to run a second smoking clinic for employees.

Christmas bazaar

Christmas Bazaar time is quickly approaching and the Friends of the Deaconess need your help in preparing for the event. All proceeds from the bazaar go into the Friends' Scholarship Fund for the School of Nursing.

The bazaar will be held from 10 a.m. - 4 p.m. on Friday, December 7. Plan your decorating for the holidays with our Christmas ornaments, centerpieces and fresh plants from the famous Lexington Gardens.

Won't you join us in making the bazaar a success? Please place salable items such as jewelry, china, books, bric-a-brac, etc., in the White Elephant barrel located in the Farr lobby. Large or fragile items may be left at the School of Nursing (Kennedy Hall, attention of Janet Clinton) or in the Volunteer Office (Harris Hall 1, attention Jane Tilley).

Knitters are needed to provide handmade knitted and crocheted items. We will supply yarn and instructions for mittens, hats and scarves. Cakes, cookies, pies, and homemade candy are also welcome at our food table. Pre-owned toys are sought for the childrens' table. Please call 732-8044 for further information.

Continuing a Tradition – *Wearing their uniforms for the first time, 69 first-year nursing students participated in the school's annual candlelighting ceremony held October 19 in Howland Auditorium. Each student carried a small lit candle in a holder believed to be a replica of the lamp carried by Florence Nightingale during the Crimean War. Thus, the ceremony gives recognition to her as the founder of modern nursing with the establishment of the first professional nursing school in 1860 at St. Thomas' Hospital in London. The Deaconess Hospital School of Nursing was founded in 1896.*

New England Deaconess Hospital **pulse**

The New England Deaconess Hospital is a 489-bed and 14-building complex. Physicians from the Joslin Clinic, the Lahey Clinic, Overholt Thoracic Clinic and the general medical and surgical staffs serve the needs of their patients at the hospital. The Deaconess is internationally known for diagnosis, treatment and research in brain and chest surgery, cancer, diabetes and general medicine, and is affiliated with Harvard Medical School.

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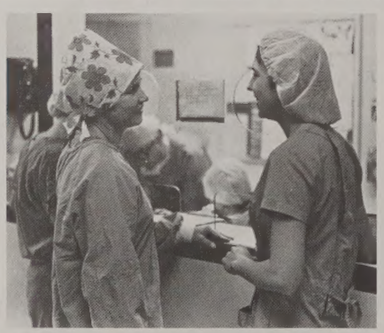

Operating room nurses provide vital function in surgical care. *(see page 1)*

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